COLORECTAL CANCER SCREENING

The Corporation will pay Covered Expenses for a colorectal cancer screening as outlined on the Schedule of Benefits.

DENTAL CARE FOR ACCIDENTAL INJURY

The Corporation will pay Covered Expenses for dental services to Natural Teeth required because of accidental injury. For purposes of this section, an accidental injury is defined as an injury caused by a traumatic force such as a car accident or a blow by a moving object. No Benefits will be made available for injuries that occur while the Member is in the act of chewing or biting. Services for conditions that are not directly related to the accidental injury are not covered. The first visit to a dentist does not require Pre-Authorization; however, the dentist must submit a plan for any future treatment to the Corporation for review and Pre-Authorization before such treatment is rendered if Covered Expenses are to be paid. Benefits are limited to treatment for only one (1) year from the date of the accidental injury.

DIABETES EDUCATION

The Corporation will pay Covered Expenses for outpatient self-management training and education for Members with diabetes mellitus provided that such training and educational Benefits are rendered by a Provider whose program:

1. Is recognized by the American Diabetes Association; or,

2. Is certified by the Diabetes Initiative of South Carolina.

DISEASE MANAGEMENT PROGRAM

The Corporation will offer Members who have an appropriate diagnosis the option to participate in the Corporation's Disease Management Program. A Member's participation in the Disease Management Program is voluntary.

DURABLE MEDICAL EQUIPMENT

The Corporation will pay Covered Expenses for standard, non-luxury (as determined by the Corporation) Durable Medical Equipment. The Corporation will decide (in its sole discretion) whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Corporation will not pay Covered Expenses for Durable Medical Equipment that is solely used by a Member in a Hospital or that the Corporation determines is included in any Hospital room charge.

EMERGENCY MEDICAL CARE

The Corporation will pay Covered Expenses for care that is necessary as a result of an Emergency Medical Condition.

GYNECOLOGICAL EXAMINATION

The Corporation will pay Covered Expenses for routine gynecological examinations each Benefit Year for female Members.

HEALTH QUESTIONS HOTLINE

The Corporation will provide Members with access to a 24 hour, health care questions hotline.

HOME HEALTH CARE

The Corporation will pay Covered Expenses for Pre-Authorized Home Health Care, including private duty nursing, when rendered to a homebound Member in the Member's current place of residence.

HOSPICE CARE

The Corporation will pay Covered Expenses for Pre-Authorized Hospice Care.

HOSPITAL AND SKILLED NURSING FACILITY SERVICES

The Corporation will pay Covered Expenses for Admissions as follows:

1. Semiprivate room, board, and general nursing care;

2. Private room, at semi-private rate as determined by the Corporation;

3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit rather than in another portion of the Hospital;

4. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;

5. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms;

6. In a Long-Term Acute Care Hospital.

Benefits for Admissions are subject to the requirements for Preadmission Review, Emergency Admission Review, and Continued Stay Review.

The day on which a Member leaves a Hospital or Skilled Nursing Facility, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Member returns to the Hospital or Skilled Nursing Facility by midnight of the same day. The day a Member enters a Hospital or Skilled Nursing Facility is treated as a day of Admission. The days during which a Member is not physically present for inpatient care are not counted as Admission days.

HUMAN ORGAN AND TISSUE TRANSPLANTS

1. The Corporation will pay Covered Expenses for certain Pre-Authorized human organ and tissue transplants. To be covered, such transplants must be provided from a human donor to a Member, and provided at a transplant center approved by the Corporation. Covered Expenses shall only be provided for the human organ and tissue transplants set forth on the Schedule of Benefits.

2. The payment of Covered Expenses for living donor transplants will be subject to the following conditions:

    a. When both the transplant recipient and the donor are Members, Covered Expenses will be paid for both.

    b. When the transplant recipient is a Member and the donor is not, Covered Expenses will be paid for both the recipient and the donor to the extent that Covered Expenses to the donor are not provided by any other source.

c. When the donor is a Member and the transplant recipient is not, no Covered Expenses will be paid to either the donor or the recipient.

3. Benefits for human organ and tissue transplants are subject to the Benefit Year Deductible amount and will be provided according to the percentage and/or dollar maximum specified on the Schedule of Benefits.

4. Human organ and tissue transplant coverage includes expenses incurred for legal donor organ and tissue procurement and all inpatient and outpatient Hospital and medical expenses for the transplant procedure and related pre-operative and post-operative care, including immunosuppressive drug therapy and air ambulance expenses.

5. Transplants of tissue as set forth below (rather than whole major organs) are Benefits under this Plan of Benefits, subject to all of the provisions of this Plan of Benefits as follows:

   a. Blood transfusions;

   b. Autologous parathyroid transplants;

   c. Corneal transplants;

   d. Bone and cartilage grafting; and

   e. Skin grafting.

IN-HOSPITAL MEDICAL SERVICE

The Corporation will pay Covered Expenses for a Physician's visit or visits to a Member during a Medically Necessary Admission for treatment of a condition other than that for which Surgical Service or obstetrical service is required as follows:

1. In-hospital medical Benefits primarily for Mental Health Services, Mental Health Conditions and Substance Abuse Services;

2. In-hospital medical Benefits in a Skilled Nursing Facility will be provided for visits of a Physician, limited to one visit per day, not to exceed the number of visits set forth on the Schedule of Benefits.

3. Where two (2) or more Physicians render in-hospital medical visits on the same day, payment for such services will be made only to one (1) Physician.

4. Concurrent medical and surgical Benefits for in-hospital medical services are only provided:

   a. When the condition for which in-hospital medical services requires medical care not related to Surgical Services or obstetrical service and does not constitute a part of the usual, necessary, and related pre-operative or post-operative care, but requires supplemental skills not possessed by the attending surgeon or his/her assistant;

   b. When the surgical procedure performed is designated by the Corporation as a warranted diagnostic procedure or as a minor surgical procedure.

5. When the same Physician renders different levels of care on the same day, Benefits will only be provided for the highest level of care

MAMMOGRAPHY TESTING

The Corporation will pay Covered Expenses for one (1) mammography test per Benefit Year regardless of Medical Necessity for female Members that are within the appropriate age guidelines. The Corporation will pay Covered Expenses for additional mammograms during a Benefit Year based on Medical Necessity.

MATERNITY MANAGEMENT PROGRAM

The Corporation will provide Members with access to the Maternity Management Program. The Maternity Management Program is designed to assist a Member in receiving prenatal care through coordination with the Member, the Provider, and the Corporation. The Maternity Management Program is not provided for a Child.

MEDICAL SUPPLIES

The Corporation will pay Covered Expenses for Medical Supplies, provided that the Corporation will not pay Covered Expenses separately for Medical Supplies that are provided as part of another Benefit.

MENTAL HEALTH CONDITIONS

The Corporation will pay Covered Expenses for Mental Health Conditions.

MENTAL HEALTH SERVICES

The Corporation will pay Covered Expenses for the inpatient and outpatient treatment for Mental Health Services.

OBSTETRICAL SERVICES

The Corporation will pay Covered Expenses for Pre-Authorized obstetrical services. Notwithstanding the preceding sentence, no maternity or obstetrical services are covered for a Member who is a Child. Midwives licensed and practicing in compliance with the Nurse Practices Act in a Hospital will be covered under this Benefit.

Under the terms of the Newborn and Mother's Health Act of 1996, the Corporation generally may not restrict Covered Expenses for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery), or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, the Corporation may not require that a Provider obtain authorization from the Corporation for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. However, Pre-Authorization is required to use certain Providers or facilities, or to reduce out-of-pocket costs.

ONLINE HEALTH ASSESSMENT PROGRAM

If specifically included on the Schedule of Benefits as a Benefit and such item does not have a "Non-Covered" notation the Corporation will provide Members with access to an online, internet based 24 hour, health care assessment service program.

ORTHOPEDIC DEVICES

The Corporation will pay Covered Expenses for Pre-Authorized Orthopedic Devices.

ORTHOTIC DEVICES

The Corporation will pay Covered Expenses for Pre-Authorized Orthotic Devices that are not available on an over-the-counter basis.

OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES

The Corporation will pay Covered Expenses for Surgical Services and diagnostic services, including radiological examinations, laboratory tests, and machine tests, performed in an outpatient Hospital setting or an Ambulatory Surgical Center.

OUTPATIENT REHABILITATION SERVICES

The Corporation will pay Covered Expenses, subject to the following paragraph, for physical therapy, occupational therapy, speech therapy and rehabilitation services as set forth on the Schedule of Benefits.

Covered Expenses for outpatient rehabilitation services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.

OXYGEN

The Corporation will pay Covered Expenses for Pre-Authorized oxygen. Durable Medical Equipment for oxygen use in a Member's home is covered under the Durable Medical Equipment Benefit.

PAP SMEAR

The Corporation will pay Covered Expenses for a pap smear as part of the annual gynecological examination Benefit regardless of Medical Necessity. The Corporation will pay Covered Expenses for additional pap smears during a Benefit Year based on Medical Necessity.

PHYSICAL EXAMINATION

The Corporation will pay Covered Expenses for an annual physical examination each Benefit Year for Members that are within the appropriate age guidelines regardless of Medically Necessity.

PHYSICIAN SERVICES

The Corporation will pay Covered Expenses for Physician Services, provided that when different levels (as determined by the Corporation) of Physician Services are provided on the same day, Covered Expenses for such Benefits will only be paid for the highest level (as determined by the Corporation) of Physician Services.

PRESCRIPTION DRUGS

1. The Corporation will pay Covered Expenses for Prescription Drugs (as specified on the Schedule of Benefits) that are used to treat a condition for which Benefits are otherwise available. Any Coinsurance percentage for Prescription Drugs is based on the Allowable Charge at the Participating Pharmacy, and does not change due to receipt of any Credits by the Corporation. Copayments likewise do not change due to receipt of any Credits by the Corporation.

2. If a Physician prescribes a Brand Name Drug and an equivalent Generic Drug is available (whether or not the Physician indicates in the prescription that the substitution of a Generic Drug is not allowed), any difference between the cost of a Generic Drug and the higher cost of a Brand Name Drug shall be the responsibility of the Member.

3. Insulin shall be treated as a Prescription Drug whether injectable or otherwise.

4. The Corporation may, in its sole discretion, place quantity limits on Prescription Drugs.

PROSTATE EXAMINATION

The Corporation will pay Covered Expenses for one (1) prostate examination per Benefit Year regardless of Medical Necessity as set forth in the Schedule of Benefits for Members that are within the appropriate age guidelines. The Corporation will pay Covered Expenses for additional prostate examinations during a Benefit Year based on Medical Necessity.

PROSTHETIC DEVICES

The Corporation will only pay Covered Expenses for Prosthetic Devices when prescribed for the alleviation or correction of conditions caused by physical injury, trauma, disease or birth defects and is an original replacement for a body part. Covered Expenses will only be paid for standard, non-luxury items (as determined by the Corporation) as a replacement of a Prosthetic Device when such Prosthetic Device cannot be repaired for less than the cost of replacement, or when a change in the Member's condition warrants replacement.

RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

In the case of a Member who is receiving Covered Expenses in connection with a mastectomy; the Corporation will pay Covered Expenses for each of the following (if requested by such Member):

1. Reconstruction of the breast on which the mastectomy has been performed; and

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prosthetic devices and treatment of physical complications at all stages of the mastectomy, including lymphedema.

REHABILITATION

The Corporation will pay Covered Expenses for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment as specified on the Schedule of Benefits if the following criteria are met:

1. All such treatment must be ordered by a medical doctor; and

2. All such treatment requires Pre-Authorization and must be performed by a Provider and at a location designated by the Corporation; and

3. The documentation that accompanies a request for rehabilitation Benefits must contain a detailed Member evaluation from a medical doctor that documents that to a degree of medical certainty the Member has rehabilitation potential such that there is an expectation that the Member will achieve an ability to provide self care and perform activities of daily living; and

4. All such rehabilitation Benefits are subject to periodic review by the Corporation.

After the initial rehabilitation period, continuation of rehabilitation Benefits will require documentation that the Member is making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.

ROUTINE ANNUAL BENEFITS

The Corporation may offer certain routine annual Benefits (typically preventive care) as set forth on the Schedule of Benefits.

SPECIALTY DRUGS

The Corporation will pay Covered Expenses for Specialty Drugs. Covered Expenses for Specialty Drugs dispensed to a Member shall not exceed the quantity and benefit maximum set by the Corporation. Specialty Drugs are medical Benefits. Any medical Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit Maximum will apply as set forth on the Schedule of Benefits. The Member may obtain a list of Specialty Drugs by contacting the Corporation at the number listed on the Identification Card or at www.SouthCarolinaBlues.com.

Any Coinsurance percentage for Specialty Drugs is based on the Allowable Charge at the Participating Pharmacy, and does not change due to receipt of any Credits by the Corporation. Copayments likewise do not change due to receipt of any Credits by the Corporation.

SUBSTANCE ABUSE SERVICES

The Corporation will pay Covered Expenses for Substance Abuse Services as set forth on the Schedule of Benefits.

SURGICAL SERVICES

The Corporation will pay Covered Expenses for Surgical Services performed by a medical doctor or oral surgeon for treatment and diagnosis of disease or injury or for obstetrical services, as follows:

1. Surgical Services, subject to the following:

    a. If two (2) or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the Allowable Charge for the major procedure only.

    b. If two (2) or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowable Charge for the operation or procedure bearing the highest Allowable Charge, plus one-half of Allowable Charge for all other operations or procedures performed.

    c. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, fifty (50%) percent for the procedure bearing the second and third highest Allowable Charges, twenty-five (25%) percent for the procedures bearing the fourth through the eighth highest Allowable Charges, and, ten (10%) percent for all other procedures. Provided, however, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, and fifty (50%) percent of the charge for each subsequent procedure.

    d. If an operation or procedure is performed in two (2) or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure.

e. If two (2) or more medical doctors or oral surgeons perform operations or procedures in conjunction with one another, other than as an assistant surgeon or anesthesiologist, the Allowable Charge, subject to the above paragraphs, will be coverage for the services of only one (1) medical doctor or oral surgeon (as applicable) or will be prorated between them by the Corporation when so requested by the medical doctor or oral surgeon in charge of the case.

f. Certain surgical procedures are designated as separate procedures by the Corporation, and the Allowable Charge is payable when such procedure is performed as a separate and single entity; however, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the Allowable Charge for the major procedure only.

2. Surgical assistant services, that consist of the Medically Necessary service of one (1) medical doctor or oral surgeon who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident, Physician's assistant or in-house Physician. The Corporation will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the medical doctor's or oral surgeon's (as applicable) actual charge.

3. Anesthesia services, that consists of services rendered by a medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.

ARTICLE IV - EXCLUSIONS AND LIMITATIONS

REGARDLESS OF LANGUAGE CONTAINED ELSEWHERE IN THIS PLAN OF BENEFITS, THE FOLLOWING ARE NOT BENEFITS UNDER THIS PLAN OF BENEFITS. THE ONLY EXCEPTION TO THIS IS WHERE SUCH ITEMS ARE SPECIFICALLY INCLUDED ON THE SCHEDULE OF BENEFITS OR AS THE LAW REQUIRES. THE CORPORATION WILL NOT PAY ANY AMOUNT FOR THE FOLLOWING:

ACUPUNCTURE

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, acupuncture treatment or services.

ACTS OF WAR

Illness contracted or injury sustained as a result of a Member's participation as a combatant in a declared or undeclared war, or any act of war, or while in military service.

ADMISSIONS THAT ARE NOT PRE-AUTHORIZED

If Pre-Authorization is not received for an otherwise Covered Expense related to an Admission, penalties will be applied (up to and including denial of the Covered Expenses) as set forth on the Schedule of Benefits.

BENEFITS PROVIDED UNDER ANY LAW

Any service or charge for a service to the extent a Member is entitled to receive payment or benefits (whether or not any such payment or benefits have been applied for or paid) pursuant to any law (now existing or as may be amended) of the United States, or any state or political subdivision thereof. This exclusion includes, but is not limited to, benefits provided by the Veterans Administration for care rendered for service-related disability, or any state or federal hospital services for which the Member is not legally obligated to pay.

BENEFITS PROVIDED BY STATE OR FEDERAL PROGRAMS

Any service or charge for a service to the extent that the Member is entitled to payment or benefits relating to such service under any state or federal program that provides health care benefits, including Medicare, but only to the extent that benefits are paid or are payable under such programs.

COMPLICATIONS FROM FAILURE TO COMPLETE TREATMENT

Complications that occur because a Member did not follow the course of treatment prescribed by a Provider, including complications that occur because a Member left a Hospital against medical advice.

COMPLICATIONS FROM NON-COVERED SERVICES

Complications arising from a Member's receipt of either services or Medical Supplies or other treatment that are not Benefits, including complications arising from a Member's use of Discount Services.

CONTRACEPTIVES

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, devices or Prescription Drugs of any type, even though dispensed by a prescription, for the purpose of contraception.

COPYING CHARGES

Fees for copying or production of medical records and/or claims filing.

COSMETIC SERVICES

1. Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, this Plan of Benefits excludes cosmetic or reconstructive procedures, and any related services or Medical Supplies, which alter appearance but do not restore or improve impaired physical function. Examples of services that are cosmetic and are not covered are:

    a. Rhinoplasty (nose);

    b. Mentoplasty (chin);

    c. Rhytidoplasty (face lift);

    d. Glabellar rhytidoplasty (forehead lift);

    e. Surgical planing (dermabrasion);

    f. Blepharoplasty (eyelid);

    g. Mammoplasty (reduction, suspension or augmentation of the breast);

h. Superficial chemosurgery (chemical peel of the face); and,

i. Rhytidectomy (abdomen, legs, hips, buttocks, or elsewhere including lipectomy or adipectomy).

2. A cosmetic service may, under certain circumstances (in the Corporation's discretion), be considered restorative in nature. In order for Benefits to be available for such restorative surgery or treatment, the restorative surgery or treatment must be:

   a. Necessary to correct or alleviate a malappearance or deformity that causes a loss of physical function or causes significant pain; or,

   b. Necessary to correct or alleviate a malappearance or deformity that was caused by physical trauma, surgery or congenital anomaly; and,

   c. The proposed cosmetic services, surgery or treatment must have been Pre-Authorized.

CUSTODIAL OR LONG-TERM CARE SERVICES

Admissions or portions thereof for custodial care or long-term care, including:

1. Rest care;

2. Long-term acute or chronic psychiatric care;

3. Care to assist a Member in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation, and taking medication);

4. Care in a sanitarium;

5. Custodial or long-term care; or,

6. Psychiatric or substance abuse residential treatment, including: Residential Treatment Centers; Therapeutic schools; Wilderness/Boot camps; Therapeutic Boarding Homes; Half-way Houses; and Therapeutic Group Homes.

DENTAL SERVICES

Any dental procedures involving tooth structures, excision or extraction of teeth, gingival tissue, alveolar process, dental X-rays, preparation of mouth for dentures, or other procedures of dental origin. However, that such procedures may be Pre-Authorized in the sole discretion of the Corporation if the need for dental services results from an accidental injury to Natural Teeth within one (1) year prior to the date of such services.

DISCOUNT SERVICES

Any charges that result from the use of Discount Services including charges related to any injury or illness that results from a Member's use of Discount Services. Discount Services are not covered under this Plan of Benefits and Members must pay for Discount Services.

EYEGLASSES

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, eyeglasses or contact lenses of any type, even though dispensed by a prescription (except after cataract surgery).

FOOD SUPPLEMENTS

Food supplements unless such food supplements are available by prescription only and are prescribed by a Physician.

FOOT CARE

Routine foot care such as paring of nails, calluses, or corns.

HEARING AIDS

Hearing aids or examinations for the prescription or fitting of hearing aids.

HUMAN ORGAN AND TISSUE TRANSPLANTS

Human organ and tissue transplants that are not:

1. Pre-Authorized; or,
2. Performed by a Provider as designated by the Corporation; or,
3. Listed as a covered transplant on the Schedule of Benefits.

IMMUNIZATIONS

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, immunizations are excluded from coverage under this Plan of Benefits.

IMPACTED TOOTH REMOVAL

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, services or Medical Supplies for the removal of impacted teeth.

IMPOTENCE

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, services, supplies or drugs related to any treatment for impotence, including but not limited to penile implants.

INCAPACITATED DEPENDENTS

Any Service, Supply or Charge for an Incapacitated Dependent that is not enrolled by the maximum Dependent Child age listed on the Schedule of Benefits.